# NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

## NOTICE OF EXEMPT RULEMAKING

### 9. HEALTH SERVICES

### CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTHCARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

### PREAMBLE

**1.** **Sections Affected** — **Rulemaking Action**

| | |
|---|---|
| R9-27-101 | Amend |
| R9-27-201 | Amend |
| R9-27-202 | Amend |
| R9-27-203 | Amend |
| R9-27-204 | Amend |
| R9-27-205 | Amend |
| R9-27-208 | Amend |
| R9-27-209 | Amend |
| R9-27-210 | Amend |
| R9-27-301 | Amend |
| R9-27-302 | Amend |
| R9-27-303 | Amend |
| R9-27-306 | Amend |
| R9-27-307 | Amend |
| R9-27-308 | Amend |
| R9-27-310 | Amend |
| R9-27-401 | Amend |
| R9-27-402 | Amend |
| R9-27-403 | Repeal |
| R9-27-404 | Repeal |
| R9-27-405 | Amend |
| R9-27-406 | Amend |
| R9-27-407 | Repeal |
| R9-27-408 | New Section |
| R9-27-502 | Repeal |
| R9-27-503 | Amend |
| R9-27-506 | Amend |
| R9-27-507 | Amend |
| R9-27-510 | Amend |
| R9-27-702 | Amend |
| R9-27-704 | Amend |
| R9-27-705 | Amend |
| R9-27-706 | New Section |
| R9-27-707 | New Section |
| R9-27-801 | Amend |

**2.** **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statute: A.R.S. § 36-2912

Implementing statute: A.R.S. § 36-2912

**3.** **The effective date of the rules:**

January 1, 2003

**4. A list of all previous notices appearing in the Register addressing the exempt rule:**

Notice of Public Meeting on Open Rulemaking Docket: 8 A.A.R. 3135, July 26, 2002

Notice of Rulemaking Docket Opening: 8 A.A.R. 3133, July 26, 2002

Notice of Public Information: 8 A.A.R. 3585, August 16, 2002

Notice of Public Meeting on Open Rulemaking Docket: 8 A.A.R. 4302, October 11, 2002

**5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Claire Sinay, Federal and State Policy Manager

Address: AHCCCS
Office of Policy Analysis and Coordination
801 E. Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone: (602) 417-4178

Fax: (602) 256-6756

**6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:**

Laws 2002, Ch. 329 § 35 exempts the Administration from rulemaking requirements of A.R.S. Title 41, Chapter 6 for the purposes of implementing changes to the Healthcare Group Program. The Administration amended all Articles in 9 A.A.C. 27 to comply with recent changes to the Healthcare Group Program by Laws 2002, Ch. 329 § 36-2912.

**7. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

None

**8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable

**9. The summary of the economic, small business, and consumer impact:**

Not applicable

**10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):**

Not applicable

**11. A summary of the principal comments and the agency response to them:**

Not applicable

**12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:**

Not applicable

**13. Incorporations by reference and their location in the rules:**

Not applicable

**14. Was this rule previously adopted as an emergency rule?**

No

**15. The full text of the rules follows:**

## 9. HEALTH SERVICES

## CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM HEALTHCARE FOR PRIVATE EMPLOYER GROUPS/AHCCCS ADMINISTERED

### ARTICLE 1. DEFINITIONS

Section
R9-27-101. Location of Definitions

**ARTICLE 2. SCOPE OF SERVICES**

Section
R9-27-201. Scope of Services
R9-27-202. Covered Services
R9-27-203. ~~Excluded Services~~ Exclusions and Limitations
R9-27-204. Out-of-service Area Coverage
R9-27-205. Outpatient Health Services
R9-27-208. Inpatient Hospital Services
R9-27-209. Emergency Medical Services
R9-27-210. Pre-existing Conditions

**ARTICLE 3. ELIGIBILITY AND ENROLLMENT**

Section
R9-27-301. Eligibility Criteria for Employer Groups
R9-27-302. Eligibility Criteria for Employee Members
R9-27-303. Eligibility Criteria for Dependents
R9-27-306. Effective Date of Coverage
R9-27-307. Open Enrollment of ~~Employee~~ Members
R9-27-308. Enrollment of Newborns
R9-27-310. Denial and Termination of Enrollment

**ARTICLE 4. CONTRACTS~~, ADMINISTRATION, AND STANDARDS~~ and GSAS**

Section
R9-27-401. General
R9-27-402. Contract and GSAs
R9-27-403. ~~Subcontracts~~ Repealed
R9-27-404. ~~Contract Amendments~~ Repealed
R9-27-405. Contract and GSA Termination
R9-27-406. Continuation Coverage
R9-27-407. ~~Conversion Coverage~~ Repealed
R9-27-408. ~~Repealed~~ Contract Compliance Sanction Alternative

**ARTICLE 5. GENERAL PROVISIONS AND STANDARDS**

Section
R9-27-502. ~~Reinsurance~~ Repealed
R9-27-503. Marketing~~,~~ and ~~Prohibition Against Inducements, Misrepresentation,~~ Discrimination~~, Sanctions~~
R9-27-506. Fraud or Abuse
R9-27-507. Release of Safeguarded Information
R9-27-510. Discrimination Prohibition

**ARTICLE 7. STANDARD FOR PAYMENTS**

Section
R9-27-702. Prohibition Against Charges to Members
R9-27-704. HCG Plan's Liability to Noncontracting ~~and Nonprovider~~ Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members
R9-27-705. Copayments
R9-27-706. Payments by Employer Groups
R9-27-707. Reinsurance

**ARTICLE 8. COORDINATION OF BENEFITS**

Section
R9-27-801. Priority of Benefit Payment

**ARTICLE 1. DEFINITIONS**

**R9-27-101. Location of Definitions**

**A.** Location of definitions. Definitions applicable to this Chapter are found in the following:

| Definition | Section or Citation |
|---|---|
| "ADHS" | R9-27-101 |
| "AHCCCS" | R9-27-101 |

| | |
|---|---|
| "Administrative law judge" | A.R.S. § 41-1092 |
| "Adverse action" | R9-27-101 |
| "Administrative review" | R9-27-101 |
| "Ambulance" | A.R.S. § 36-2201 |
| "Certification" | 29 U.S.C. 1181 |
| "Clean claim" | A.R.S. § 36-2904 |
| "Coinsurance" | R9-27-101 |
| "Complainant" | R9-27-101 |
| "Copayment" | R9-27-101 |
| "Covered services" | R9-27-101 |
| "Creditable coverage" | A.R.S. § 36-2912 |
| "Date of notice" | R9-27-101 |
| "Day" | R9-27-101 |
| "Deductible" | R9-27-101 |
| "Dependent" | R9-27-101 |
| "Durable medical equipment" or "DME" | R9-27-101 |
| "Eligible employee" | A.R.S. § 36-2912 |
| "Emergency ambulance service" | R9-27-101 |
| "Emergency medical services" | R9-27-101 |
| "Employee member" | R9-27-101 |
| "Employer group" | R9-27-101 |
| "Enrollment" | R9-27-101 |
| "Experimental Services" | R9-22-101 |
| "Full-time employee" | R9-27-101 |
| "Grievance" | R9-27-101 |
| "Group Service Agreement" or "GSA" | R9-27-101 |
| "Healthcare Group Administration" or "HCGA" | R9-27-101 |
| "HCG" | R9-27-101 |
| "HCG Plan" | R9-27-101 |
| "Health care practitioner" | R9-27-101 |
| "Hearing" | R9-27-101 |
| "Hospital" | R9-27-101 |
| "Inpatient hospital services" | R9-27-101 |
| "Late enrollee" | A.R.S. § 36-2912 |
| "Life threatening" | R9-27-101 |
| "Medical record" | R9-27-101 |
| "Medical services" | A.R.S. § 36-401 |
| "Medically necessary" | R9-27-101 |
| "Member" | R9-27-101 |
| "Noncontracting provider" | R9-27-101 |
| "Office of Administrative Hearings" or "OAH" | A.R.S. § 41-1092 |
| "Outpatient service" | R9-27-101 |
| "Party" | R9-27-101 |
| "Pharmaceutical service" | R9-27-101 |
| "Physician service" | R9-27-101 |
| "Political subdivision" | R9-27-101 |
| "Pre-existing condition" | A.R.S. § 36-2912 |

| | |
|---|---|
| "Pre-existing condition exclusion" | A.R.S. § 36-2912 |
| "Premium" | R9-27-101 |
| "Pre-payment" | R9-27-101 |
| "Prescription" | R9-27-101 |
| "Primary care practitioner" | R9-27-101 |
| "Primary care provider" | R9-27-101 |
| "Prior authorization" | R9-27-101 |
| "Quality management" | R9-27-101 |
| "Referral" | R9-27-101 |
| "Respondent" | R9-27-101 |
| "Scope of services" | R9-27-101 |
| "Service area" | R9-27-101 |
| "Spouse" | R9-27-101 |
| "Subcontract" | R9-27-101 |
| "Utilization control" | R9-27-101 |
| "Utilization review" | R9-27-101 |
| "Waiting period" | A.R.S. § 36-2912 |

**B.** Definitions. In addition to the definitions contained in A.R.S. Title 36, Chapter 29, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"ADHS" means the Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

"AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible member.

~~"Administrative law judge" means the person defined in A.R.S. § 41-1092.~~

"Adverse action" means any action under this Chapter, including adverse eligibility actions, for which a party may file a grievance or request a hearing under A.R.S. § 41-1092 et seq. under 9 A.A.C. 27, Article 6.

"Administrative review" means that portion of the grievance process beginning with the filing of a grievance with the Administration or its contractor and concluding with the issuance of a final decision by the Administration or its contractor that advises the party of formal hearing rights under A.R.S. § 41-1092 et seq.

~~"Ambulance" means any vehicle defined in A.R.S. § 36-2201.~~

~~"Certification" as specified in 29 U.S.C. 1181.~~

~~"Clean claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.~~

"Coinsurance" means a predetermined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.

"Complainant" means an applicant, member, person, or entity filing a grievance or request for hearing.

"Copayment" means a monetary amount specified by the HCGA that a member or dependent pays directly to a provider at the time a covered service is rendered.

"Covered services" means the health and medical services described in 9 A.A.C. 27, Article 2.

~~"Creditable coverage" as defined in A.R.S. § 36-2912.04.~~

"Date of notice" means the date on a notice of action.

"Day" means a calendar day unless otherwise specified in the text.

"Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the HCG Plan agrees to pay.

"Dependent" means the eligible spouse and children of an employee member under 9 A.A.C. 27, Article 3.

"Durable Medical Equipment" or "DME" means durable items or appliances, as determined by the HCG Plan to be a medically necessary item or supply and a benefit under the Employer's GSA. The DME is:

Able to withstand repeated use;
Designed to serve a medical purpose;

Generally not useful to a person in the absence of a medical condition, illness, or injury;
Not customarily found in a physician's office;
Is not disposable; and
Is needed for functional rather than cosmetic reasons.

~~"Eligible employee" means an employee who is eligible for HCG coverage under 9 A.A.C. 27, Article 3.~~

"Emergency ambulance service" means:
Transportation by an ambulance or air ambulance company for a member requiring emergency medical services.
Emergency medical services that are provided by a person certified by the ADHS to provide the services before, during, or after a member is transported by an ambulance or air ambulance company.

"Emergency medical services" means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:
Placing a patient's health in serious jeopardy,
Serious impairment to bodily functions, or
Serious dysfunction of any bodily organ.

"Employer group" means the aggregate enrollment of an ~~employed~~ employer group or business ~~that is contracting~~ with a HCG Plan for covered services.

"Employee member" means an enrolled employee of an employer group.

"Enrollment" means ~~the process by which an employer group or a member applies for coverage and contracts with an HCG Plan.~~ the process by which an applicant applies for coverage under an employer group contracted with HCGA.

"Full-time employee" means an employee who works at least ~~32~~ 20 hours per week and expects to continue employment for at least five months following enrollment.

"Grievance" means a complaint that initiates an administrative review that does not involve a hearing under A.R.S. § 41-1092 et seq. A party may request a hearing under A.R.S. § 41-1092 et seq. after an administrative review.

"GSA" means Group Service Agreement, a contract between an employer group and ~~an HCG Plan~~ HCGA.

"Healthcare Group Administration ~~(HCGA)~~" or "HCGA" means the section within AHCCCS that directs, determines eligibility, and regulates the continuous development and operation of the HCG Program.

"HCG" means Healthcare Group of Arizona, the registered name of the Healthcare Group Program, a prepaid medical coverage product marketed by the ~~Healthcare Group Plans~~ HCGA to small uninsured businesses and political subdivisions within the state.

"HCG Plan" means a Healthcare Group prepaid health plan that is currently under contract with the HCGA to provide covered services to a member of an employer group.

~~"Health care practitioner" means a person other than a physician who is licensed or certified under Arizona law to deliver health care services.~~

"Health care practitioner" means a:
Physician,
Physician assistant,
Nurse practitioner; or
Other person who is licensed or certified under Arizona law to deliver health care services.

"Hearing" means an administrative hearing under Title 41, Chapter 6, Article 10.

"Hospital" means a health care institution licensed as a hospital by the ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.

"Inpatient hospital services" means a medically necessary service that requires an inpatient stay in an acute care hospital. An inpatient hospital service is provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

~~"Late enrollee" as specified in A.R.S. § 36-2912.04.~~

"Life threatening" means any condition for which a delay in obtaining pre-authorization or traveling to an approved medical facility would have a severe adverse effect on a patient's condition.

"Medical record" means a single, complete record kept at the site of a member's primary care provider that documents the medical services received by a member, including inpatient discharge summary, outpatient care, and emergency care.

~~"Medical services" means health care services provided or prescribed to a member by a physician, a nurse, or other health care practitioner, and technical personnel at the direction of a physician.~~

"Medically necessary" means covered services provided by a physician or other health care practitioner within the scope of the physician's or other health care practitioner's practice under state law to:

Prevent disease, disability, and other adverse health condition or its progression; or

Prolong life.

"Member" means an employee or a dependent who is enrolled with an HCG Plan.

"Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.

~~"OAH" means the Office of Administrative Hearings defined in A.R.S. § 41-1092 et seq.~~

"Outpatient service" means a medically necessary service that may be provided in any setting on an outpatient basis that does not require an overnight stay in an inpatient hospital. An outpatient service is provided by or under the direction of a physician or other health care practitioner, upon referral from a member's primary care provider.

"Party" means a person or entity by or against whom a grievance or request for hearing is brought.

"Pharmaceutical service" means a medically necessary medication prescribed by a physician, a practitioner, or a dentist upon referral by a primary care provider and dispensed under 9 A.A.C. 27, Article 2.

"Physician service" means a service provided within the scope of practice of medicine or osteopathy as defined by state law, by, or under the direction of a person licensed under state law to practice medicine or osteopathy.

"Political subdivision" means the state of Arizona, a county, a city, a town, or a school district within the state.

~~"Pre-existing condition" as specified in A.R.S. § 36-2912.04.~~

~~"Pre-existing condition exclusion" as specified in A.R.S. § 36-2912.~~

"Premium" means the monthly pre-payment submitted to HCGA by the employer group.

"Pre-payment" means submission of the employer group's premium payment 30 days in advance of the effective date of coverage under 9 A.A.C. 27, Article 3.

"Prescription" means an order for covered services for a member that is signed or transmitted by a provider licensed under applicable state law to prescribe or order the service.

"Primary care practitioner" means a physician assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.

"Primary care provider" means a member's primary care physician or a primary care practitioner.

"Prior authorization" means the process by which the HCG Plan authorizes, in advance, the delivery of a covered service.

"Quality management" means a methodology used by professional health personnel to assess the degree of conformance to desired medical standards and practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.

"Referral" means the process by which a primary care provider directs a member to another appropriate provider or resource for diagnosis or treatment.

"Respondent" means a party responsible for the adverse action that is the subject of a grievance or request for hearing.

~~"Rider" or "contract rider" means an amendment to the GSA between an employer group and an HCG Plan.~~

"Scope of services" means the covered, limited, and excluded services listed in 9 A.A.C. 27, Article 2.

"Service area" means the geographic area designated by HCGA where each HCG Plan shall provide covered health care benefits to members directly or through subcontracts.

"Spouse" means a husband or a wife of an HCG member who has entered into a marriage recognized as valid by Arizona.

"Subcontract" means an agreement entered into by an HCG Plan with any of the following:

A provider of health care services who agrees to furnish covered services to members,

A marketing organization, or

Any other organization to serve the needs of the HCG Plan.

~~"Subscriber" means an enrolled employee of an employer group.~~

~~"Subscriber agreement" means a contract between an employee member and an HCG Plan.~~

"Utilization control" means an overall accountability program encompassing quality management and utilization review.

"Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.

~~"Waiting period" as specified in A.R.S. § 36-2912.04.~~

## ARTICLE 2. SCOPE OF SERVICES

**R9-27-201. Scope of Services**

**A.** ~~HCG Plan to~~ HCGA shall provide a list of covered services to each HCG Health Plan. Each HCG Plan shall provide, either directly or through subcontracts, a list of the covered services specified in this Article.

**B.** Provision of covered services. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.

**C.** Scope of covered services. An HCG Plan ~~may~~ shall not further delineate, expand, or limit the ~~scope~~ list of covered services ~~through a rider in the GSA with prior written approval from the HCGA.~~ beyond the standard covered services under this Article or GSA.

**R9-27-202. Covered Services**

Covered services. Subject to the exclusions and limitations specified in these rules and the GSA, ~~the following services shall be covered by the HCG Plans:~~ an HCG Plan shall cover the following services:

1. Outpatient services;
2. Laboratory, radiology, and medical imaging services;
3. Prescription drugs;
4. Inpatient hospital services;
5. Emergency medical services ~~as specified in~~ under R9-27-209 in and out of the service area;
6. Emergency ambulance services;
7. Maternity care;
8. Cornea transplants; ~~and~~
9. Kidney transplants~~.~~ ;
10. Durable medical equipment, orthotics, and prostheses as specified in the GSA; and
11. Other services as agreed under the GSA.

**R9-27-203. ~~Excluded Services~~ Exclusions and Limitations**

**A.** Excluded medical services. Any medical service not specifically provided for in this Article ~~or in a rider~~ is not a covered medical service.

**B.** Excluded services. ~~The following services shall not be covered:~~ An HCG Plan shall not cover the following:

1. Services or items furnished solely for cosmetic purposes except for breast reconstruction performed by an HCG Plan following a mastectomy, and services or items provided to reconstruct or improve personal appearance after an illness or injury as specified in the GSA;
2. Services or items requiring prior authorization for which prior authorization has not been obtained;
3. Services or items furnished gratuitously or for which charges are not usually made;
4. Hearing aids, eye examinations for prescriptive lenses, ~~and~~ prescriptive lenses and surgery for the correction of myopia;
5. Long-term care services, including nursing services;
6. Private or special duty nursing services, provided in a hospital unless medically necessary and prior authorized by the HCG Plan Medical Director.
7. Care for health conditions that are required by state or local law to be treated in a public facility;
8. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;
9. Gastric stapling or diversion for weight loss;
10. Reports, evaluations, or physical examinations not required for health reasons including employment, insurance, or governmental licenses, sports, and court-ordered forensic or custodial evaluations;
11. Treatment of temporomandibular joint dysfunction, unless treatment is prior authorized and determined medically necessary by the HCG Plan Medical Director or designee;
12. ~~Elective abortions;~~ Pregnancy termination under A.R.S. § 35-196.02;
13. Medical and hospital care and costs for the child of a dependent, unless the child is otherwise eligible under the GSA;
14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities;
15. ~~Sex change operations~~ Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);
16. Services not deemed medically necessary by the HCG Plan Medical Director, or the responsible primary care provider;
17. Routine foot care;

18. ~~Charges for administrative costs separately billed for blood and blood products;~~ Blood products, blood derivatives, synthetic blood, including artificial and genetic derivatives and coagulation factors and the associated charges for the administrative costs which are separately billed;
19. Organ transplants except as specified in R9-27-202;
20. Bone marrow transplants including autologous, allogeneic-related, and allogeneic-unrelated;
21. Mental health services;
22. ~~Durable medical equipment;~~ Acupuncture;
~~23. Artificial implants;~~
~~24.~~23. Dental services;
~~25.~~24. Transportation other than emergency ambulance services;
~~26.~~25. Psychotherapeutic drugs;
~~27. Charges for injuries incurred as the result of participating in a riot, or committing, or attempting to commit a felony or assault, or by suicide attempt;~~
26. Charges for injuries incurred as the result of:
    a. Participating in a riot;
    b. Committing, or attempting to commit a felony or assault;
    c. Committing intentional acts of self inflicted injuries; or
    d. Attempting suicide.
~~28. Early and periodic screening, diagnosis and treatment services (EPSDT);~~
~~29.~~27. ~~In~~ Infertility testing, in vitro fertilization and all other fertilization treatments;
~~30.~~28. Allergy testing and hyposensitization treatment; ~~and~~
~~31.~~29. Experimental services as determined by the HCGA, or services provided primarily for the purpose of research~~.~~;
30. Alternative medicine;
31. Chiropractic services;
32. Osteopathic manipulation therapy; and
33. Other services under the GSA.

**C.** Limitations. When providing covered services, the HCG Plan shall adhere to the coverage limitations in this Article, the GSA, and the following:
1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons.
2. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary as determined by the HCG Plan Medical Director, or designee.
3. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
4. Hospice services are limited to the terms in the GSA.
5. Home infusion therapy is limited to the terms in the GSA.
6. Home Health Care is limited to the terms in the GSA.

**R9-27-204. Out-of-service Area Coverage**

Out-of-service area coverage. As specified in R9-27-209, a member is entitled to only emergency services when outside the member's HCG Plan service area. The Administration shall not cover services outside the United States.

**R9-27-205. Outpatient Health Services**

Outpatient services. The HCG Plan shall provide the following covered ~~outpatient~~ services if medically necessary:
1. Ambulatory surgery and anesthesiology services not specifically excluded;
2. Physician's services;
3. Pharmaceutical services and prescribed drugs to the extent authorized in this Article~~, and applicable provider contracts;~~ and under the GSA;
4. Laboratory services;
5. Radiology and medical imaging services;
6. Services of other health care practitioners when supervised by a physician;
7. Nursing services provided in an outpatient health care facility;
8. The use of emergency, examining, or treatment rooms when required for the provision of physician services;
~~9. Home physician visits, as medically necessary;~~
~~10.~~9. Specialty care physician services referred by a primary care provider or health plan;
~~11.~~10. Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic work-ups that include ~~tasks~~ treatments or procedures to:
    a. Determine risk of disease,
    b. Provide early detection of disease,
    c. Detect the presence of injury or disease at any stage,
    d. Establish a treatment plan for injury or disease at any stage,

e. Evaluate the results or progress of a treatment plan or treatment decision, or
f. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.

~~12.~~11. Short-term rehabilitation ~~and physical therapy may be~~ is provided ~~for a 60-day period,~~ as specified in the GSA, if in the judgment of the HCG Plan Medical Director or designee, the treatment can be expected to result in the significant improvement of a member's condition.

**R9-27-208. Inpatient Hospital Services**

**A.** Inpatient hospital services. The HCG Plan shall provide the following inpatient hospital covered services if medically necessary:
1. Routine services, including:
   a. Hospital accommodations;
   b. ~~Intensive care and coronary care units;~~ Specialty units;
   c. Nursing services necessary and appropriate for a member's medical condition;
   d. Dietary services;
   e. Medical supplies, appliances, and equipment furnished to hospital inpatients, billed as part of routine services, and included in the daily room and board charge;
2. Ancillary services, including:
   a. Labor, delivery and recovery rooms, and birthing centers;
   b. Surgery and recovery rooms;
   c. Laboratory services;
   d. Radiological and medical imaging services;
   e. Anesthesiology services;
   f. Rehabilitation services as specified in the GSA;
   g. Pharmaceutical services and prescribed drugs;
   h. Respiratory therapy;
   i. Maternity services;
   j. Nursery and related services;
   k. Chemotherapy; and
   l. Dialysis as limited in this Article.

**B.** Limitations. The HCG ~~Plans~~ Plan shall adhere to the following coverage limitations when providing inpatient hospital services:
1. Inpatient hospital accommodations are limited to no more than a semi-private rate, except when a patient must be isolated for medical reasons.
2. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.
3. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary as determined by the HCG Plan Medical Director, or designee.

**R9-27-209. Emergency Medical Services**

**A.** Emergency medical services provided within the HCG Plan's service area.
1. Emergency medical services shall be provided to a member 24 hours-a-day, 7 days-a-week based on the prudent layperson standard ~~specified in~~ under 42 U.S.C. 1396u-2. ~~, August 5, 1997, which is incorporated by reference and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~
2. The member or provider shall notify the HCG Plan no later than 24 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 24 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.

**B.** Emergency medical services provided outside the HCG Plan's service area.
1. Emergency medical services provided outside the HCG Plan's service area is based on the prudent layperson standard ~~as specified in~~ under 42 U.S.C. 1396u-2. ~~, August 5, 1997, incorporated by reference in subsection (A)(1).~~
2. The member or provider shall notify the HCG Plan no later than 48 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan no later than 48 hours after the member is capable of verifying coverage under the HCGA. Failure to provide timely notice constitutes cause for denial of payment.

**C.** Ambulance services.
1. Within the HCG Plan's service area. A member is entitled to emergency ambulance services within the HCG Plan's service area. The provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.
2. Outside the HCG Plan's service area. A member is entitled to ambulance services outside the HCG Plan's service area to transport the member to the nearest medical facility capable of providing necessary emergency services. The

provider shall notify the HCG Plan within 10 working days after providing emergency ambulance service to the member. Failure to provide notice within 10 working days constitutes cause for denial of payment.

**R9-27-210. Pre-existing Conditions**

**A.** Pre-existing conditions exclusions. Subject to subsection (B), an HCG Plan shall not cover any services related to a pre-existing condition as specified in ~~A.R.S. § 36-2912(Q)~~ A.R.S. § 36-2912.

**B.** Failure to impose a pre-existing condition exclusion. An HCG Plan shall not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:
1. Newborns from the time of birth if enrolled within the time-frames under R9-27-308;
2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
   a. A person who had continuous coverage for a one-year period and during that year had no breaks in coverage totaling more than 31 days; and
   b. A person's prior coverage ended within 63 days before the date of ~~application for~~ enrollment.

**C.** Credit for prior health coverage. An HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of one month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan under A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan that provided continuous coverage to an individual shall disclose the coverage provided.

**D.** Late enrollee pre-existing conditions time-frames. An HCG Plan shall exclude coverage for a preexisting condition for a late enrollee under A.R.S. § 36-2912 as follows:
1. For 12 months if the member enrolls within 30 days of the designated enrollment time-frame, or
2. For 18 months if the member enrolls 31 or more days after the designated time-frame for enrollment.

## ARTICLE 3. ELIGIBILITY AND ENROLLMENT

**R9-27-301. Eligibility Criteria for Employer Groups**

**A.** Criteria for employer groups.
1. An employer group shall conduct business:
   a. ~~within~~ Within Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage~~.~~ ; and
   b. Within a county which has an HCG Plan.
2. The ~~HCG Plan~~ HCGA shall determine eligibility for an employer group and its employees ~~by using one or more of the following documents~~ through documentation of one or more of the following:
   ~~1.~~a. Participation in state unemployment insurance~~,~~ ;
   ~~2.~~b. Participation in state worker's compensation~~,~~ ;
   ~~3.~~c. ~~Possession of a state tax identification number,~~ Personal tax return with schedule C, SE, or SEZ; or
   ~~4.~~d. Other verifiable proof that the applicant is conducting a business in Arizona.

**B.** Amount of ~~full-time~~ eligible employees and enrollment. Other than the state of Arizona and political subdivisions of the state, an employer group shall have a minimum of one and a maximum of 50 ~~full-time~~ eligible employees at the effective date of the first ~~contract~~ GSA with ~~an HCG Plan~~ HCGA. Acceptable proof of the number of ~~full-time~~ eligible employees may include canceled checks, bookkeeping records, and personnel records.

**C.** Required enrollment of a particular number of employees. Other than state employees and employees of political subdivisions of the state, employers with one to 50 eligible employees may contract with ~~an HCG Plan~~ HCGA if the employer:
1. Has five or fewer ~~full-time~~ eligible employees and enrolls 100% of these employees in an HCG Plan, or
2. Has six or more ~~full-time~~ eligible employees and enrolls 80% of these employees in an HCG Plan.

**D.** HCGA does not include employees who work less than 20 hours per week when determining participation requirements.

~~D.~~**E.** Employees with proof of other insurance. Employees with proof of existing health care coverage who elect not to participate in an HCG Plan shall not be considered when determining the percentage of the required number of enrollees if the health care coverage is:
1. Group coverage offered through a spouse, a parent, or a legal guardian; or
2. Coverage available from a government-subsidized health care program.

~~E.~~**F.** Post-enrollment changes in group size. Changes in group size that occur during the term of the GSA shall not affect eligibility.

~~F. Review and verification of eligibility determinations.~~
~~1. An HCG Plan may conduct random reviews of eligibility determinations of an employer group and its employees.~~
~~2. The HCGA may conduct random reviews of eligibility determinations completed by an HCG Plan.~~

**G.** Review and verification of eligibility determinations. The HCGA may conduct random reviews of eligibility determinations of an employer group and its employees.

**R9-27-302. Eligibility Criteria for Employee Members**

**A.** Residence. An employee member shall reside, work, or reside and work in Arizona and in a county with an HCG Plan.

**B.** Eligible employer group. An employee member shall be employed by an eligible employer group specified in R9-27-301.

**C.** Days of consecutive employment. An employee member shall have been employed at least 60 consecutive days before the effective date of coverage.

**D.** Hours of employment per week. ~~An employee~~ A member working for an employer group or a self-employed person shall work ~~for the employer group~~ at least ~~32~~ 20 hours per week, with anticipated employment of at least five months following enrollment.

**E.** Eligibility for government subsidized health care programs. The HCGA shall provide written information to members who may be eligible for a government subsidized health care program.

**R9-27-303. Eligibility Criteria for Dependents**

**A.** Eligible dependents. An eligible dependent of an employee member shall reside in Arizona, in a county with an HCG Plan and includes:
1. A legal spouse;
2. Unmarried children less than the age of 19 or less than the age of 24 if the child is a full-time student and is ~~a~~:
   a. A ~~Natural~~ natural child,
   b. An ~~Adopted~~ adopted child,
   c. A ~~Step-child~~ step-child, or
   d. A ~~Child~~ child for whom the employee member is a legal guardian.
3. A child incapable of self-sustaining support by reason of mental or physical disability existing before the child's 19th birthday, as determined by the HCG Plan Medical Director or designee.

**B.** Limitations. A grandchild of an employee member shall be eligible to receive covered services only if the grandchild meets the eligibility requirements ~~of R9-27-303(A)(2) or (3).~~ in subsection (A)(2)(b), (c), and (d) or (A)(3).

**R9-27-306. Effective Date of Coverage**

**A.** Payment in advance of effective date. Employer groups shall submit payment 30 days in advance of the effective date of coverage. ~~The effective date of coverage shall be the first day of the month for which the premium has been pre-paid.~~ If the Administration receives the full premium payment on or before the 15th day of the month, enrollment will begin on the first day of the next month. If the Administration receives the full premium payment after the 15th day of the month, coverage begins on the first day of the second month. No retroactive coverage is available.

**B.** Other effective date options. For other effective date options, an employer group shall complete and submit the enrollment documents and initial premium payment by the time-frames specified in the GSA.

**R9-27-307. Open Enrollment of ~~Employee~~ Members**

**A.** Open enrollment. Enrollment of an employee member shall occur only during one of the following open enrollment periods:
1. ~~Thirty-one~~ Thirty days following the effective date of the GSA for a newly enrolled employer group;
2. A 31-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 31-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever period is greater; or
3. A 31-day period to begin 105 days before and conclude at least 75 days before the employer group's renewal date, as determined by the HCGA.

**B.** New dependent enrollment. Enrollment of new dependents shall occur:
1. Within the 31-day period following the addition of a new dependent defined in R9-27-303(A), or
2. Under R9-27-308 if the dependent is a newborn.

**R9-27-308. Enrollment of Newborns**

Newborn enrollment. A newborn shall be enrolled ~~within~~ 30 days ~~of~~ following the birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA ~~within~~ 30 days ~~of~~ following the birth for coverage retroactive to the first day of the month in which the birth occurred.

**R9-27-310. Denial and Termination of Enrollment**

**A.** Denial of enrollment. An employer group, an employee, or a dependent who fails to meet the requirements of this Article shall be denied enrollment.

**B.** Termination of enrollment. Termination of enrollment and coverage for an employer group, an employee member, or a dependent shall occur on the last day of the month that:
1. The employer group loses eligibility,
2. The employee member loses eligibility, or
3. The dependent loses eligibility.

**C.** Exclusion from enrollment. The ~~HCG Plan~~ HCGA may exclude an employer group or an employee member from enrollment who has committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

## ARTICLE 4. CONTRACTS~~, ADMINISTRATION, AND STANDARDS~~ and GSAS

### R9-27-401. General

**A.** Contracts to provide services. The HCGA shall establish contracts to provide services with qualified HCG Plans ~~as specified in this Article and A.R.S. Title 36, Chapter 29~~ under A.R.S. § 36-2912.

**B.** GSAs with employer groups. The HCGA shall establish GSAs with employer groups under A.R.S. § 36-2912.

**~~B.~~C.** Contracts and ~~subcontracts~~ GSAs. Contracts and ~~subcontracts~~ GSAs entered into under ~~this Article~~ A.R.S. § 36-2912 and on file with the HCGA are public records unless otherwise made confidential by law.

### R9-27-402. Contracts and GSAs

**A.** Requirements for a health plan. A health plan ~~must~~ shall meet the requirements of A.R.S. § 36-2912 and ~~this Article to contract with the HCGA.~~ all HCGA contract requirements.

~~**B.** Contract requirements. Each contract shall be in writing and include the following information:~~

~~1. The method and amount of compensation or other consideration an HCG Plan will receive;~~
~~2. The HCG Plan's name and address;~~
~~3. The population and geographic service area the contract will cover;~~
~~4. The amount, duration, and scope of medical services an HCG Plan will provide and for which compensation will be paid;~~
~~5. The term of the contract, including the beginning and ending dates, as well as methods of extension, re-negotiation, and termination;~~
~~6. A provision that the HCG Plan arrange for the collection of any required copayment, coinsurance, deductible, or third-party insurance;~~
~~7. A provision that the HCG Plan will not bill or attempt to collect a copayment, a coinsurance, a deductible, or third-party insurance from a member for any covered service except as may be authorized by statute, these rules, or contract riders that are approved by the HCGA;~~
~~8. A provision that the contract will not be assigned or transferred without the prior written approval of the HCGA;~~
~~9. Procedures for the covered population's enrollment;~~
~~10. Procedures and criteria for terminating or suspending the contract;~~
~~11. A provision that the HCG Plan will hold harmless and indemnify the state, AHCCCS, HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to third parties, that may accrue against the state, AHCCCS, HCGA, or members, through the negligence or other action of the HCG Plan; and~~
~~12. A provision that an HCG Plan demonstrate it has an adequate network of providers.~~

**B.** Requirements for an employer group. An employer group shall meet the requirements of A.R.S. § 36-2912 and all GSA requirements.

### R9-27-403. ~~Subcontracts~~ Repealed

~~**A.** Approval. Any subcontract entered into by an HCG Plan to provide covered services to an HCG member is subject to review and approval of the HCGA. A provider subcontract does not alter the legal responsibility of the HCG Plan to the HCGA. The HCGA shall ensure that all activities under the contract are carried out.~~

~~**B.** Subcontract requirements. Each subcontract shall be in writing and include:~~

~~1. A specification that the subcontract will be governed by and construed under all laws, rules, and contractual obligations of the HCG Plan;~~
~~2. A provision that the HCG Plan will notify the HCGA in the event a subcontract with an HCG Plan is entered into, amended, or terminated;~~
~~3. A provision that assignment or delegation of a subcontract is void unless the HCGA gives prior written approval;~~
~~4. An agreement to hold the state, AHCCCS, the HCGA, and members harmless in the event the HCG Plan is unable to or does not pay for covered services performed by a subcontractor;~~
~~5. A provision that the HCGA may review and give prior written approval for a subcontract and a subcontract amendment and that the HCGA may terminate, rescind, or cancel a subcontract or a contract amendment for violation of these rules;~~
~~6. An agreement to hold harmless and indemnify the state, AHCCCS, the HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to third parties, that may accrue against the state, AHCCCS, the HCGA, or members, through the negligence or other action of a subcontractor;~~
~~7. The method and amount of compensation or other consideration a subcontractor will receive; and~~
~~8. The amount, duration, and scope of medical services a subcontractor will provide and for which compensation will be paid.~~

~~**C.** Waiver of requirement to contract with hospitals. An HCG Plan may submit a written request to the HCGA requesting a waiver of the requirement that the HCG Plan subcontract with a hospital in the HCG Plan's service area as specified in R9-27-402(12). The request shall state the reasons for a waiver and all efforts made to secure a subcontract with a hospital within the HCG Plan's service area. For good cause shown, the HCGA may waive the hospital subcontract requirement. The HCGA shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:~~

~~1. The number of hospitals in the service area;~~
~~2. The extent to which the HCG Plan's primary care providers have staff privileges at noncontracting hospitals in the service area;~~
~~3. The size and population of, and the demographic distribution within, the service area;~~
~~4. The patterns of medical practice and care within the service area;~~
~~5. Whether the HCG Plan has diligently attempted to negotiate a hospital subcontract in the service area;~~
~~6. Whether the HCG Plan has any subcontracts in adjoining areas with hospitals that are reasonably accessible to the HCG Plan's members in the service area; and~~
~~7. Whether the HCG Plan's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.~~

**R9-27-404. ~~Contract Amendments~~ Repealed**

~~**A.** Merger, reorganization, change of ownership. Any merger, reorganization, or change in ownership of an HCG Plan or a subcontractor affiliated with the HCG Plan shall constitute an HCGA contract amendment.~~
~~**B.** Written approval necessary. The HCG Plan shall obtain written approval from the HCGA, before any merger, reorganization, or change in ownership of an HCG Plan or a subcontractor that is related to or affiliated with the HCG Plan.~~
~~**C.** Contract amendment requirements. To be effective, contract amendments shall be submitted in writing to the HCGA and executed by both parties.~~

**R9-27-405. Contract and GSA Termination**

**A.** Contract between the HCGA and an HCG Plan. Under this Article and as specified in contract, ~~The~~ the HCGA may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:
1. Submission of any misleading, false, or fraudulent information;
2. Provision of any services in violation of or not authorized by licensure, certification, or other law;
3. A material breach of contract;
4. Failure to provide and maintain quality health care services to members, as determined by standards established by the state; and
5. Failure to reimburse a medical provider within 60 days of receipt of a clean claim unless a different period is specified by contract.

~~**B.** Group Service Agreement between HCG Plan and employer group.~~
~~1. The GSA may be terminated with written notice from either the HCG Plan or employer to the other party no more than 60 days, and at least 45 days before the anniversary date of the GSA.~~
~~2. The GSA may be terminated by the HCG Plan for cause with 10 days' written notice for the following:~~
~~a. Material misrepresentation of information furnished by the employer to the Plan, or~~
~~b. Employer's default in payment of premiums, time being of the essence.~~
~~3. The GSA may be terminated by the employer group or the HCG Plan with 45 days' written notice for a material breach of the contract.~~

**B.** Group Service Agreement between the HCGA and an employer group. The GSA may be terminated with written notice from either the HCGA or an employer group to the other party within time-frames specified in the GSA.

**C.** Termination of ~~an employee~~ a member by the HCGA or HCG Plan.
1. Cause for immediate termination of coverage. The HCGA or HCG Plan may terminate ~~an employee~~ a member's coverage for the following:
   a. Fraud or misrepresentation when applying for coverage or obtaining services; or
   b. Violence, or threatening or other substantially abusive behavior toward the HCGA or the HCG Plan employees or agents, or contracting or noncontracting providers or their employees or agents.
2. Cause for termination with 30 days written notice. The HCGA or the HCG Plan may terminate coverage of ~~an employee~~ a member for the following reasons:
   a. Repeated and unreasonable demands for unnecessary medical services;
   b. Failure to pay any copayment, coinsurance, deductible, or required financial obligation; and
   c. Material violation of any provision of the ~~Group Service Agreement~~ GSA.
3. Termination by reason of ineligibility.
   a. Termination of employment;
   b. Failure of employer ~~or employee~~ to pay premium. Termination shall be effective the first day of the month for which the premium has not been paid;
   c. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member loses coverage, for any reason described in R9-27-406 ~~and R9-27-407~~.
   d. Subject to continuation coverage ~~and conversion coverage~~, as described in R9-27-406 ~~and R9-27-407~~, on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a member whose coverage has been terminated; except that a member confined to a hospital at the

effective date of termination shall continue to receive coverage until there has been a determination by the HCG Plan Medical Director or designee that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital; and

e. An employee member whose coverage terminates according to this subsection shall not be eligible for re-enrollment until the employer group's next open enrollment period. The employee shall meet all the eligibility criteria prescribed by these rules before re-enrollment.

**D.** The ~~HCG Plan~~ HCGA may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

**R9-27-406. Continuation Coverage**

Continuation coverage. Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by 29 U.S.C. 1161 et seq.~~, December 19, 1989, incorporated by reference and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.~~ The employer group shall collect the premium from the employee and pay the premium to HCGA.

**R9-27-407. ~~Conversion Coverage~~ Repealed**

~~Conversion coverage. Conversion coverage applies only to an employee member and dependents of an employer group with fewer than 20 employees.~~

~~1. An employee member, a dependent, or a qualified beneficiary who loses eligibility for a qualifying event, as defined in 29 U.S.C. 1163, and who has been covered for at least three months under the GSA may convert the policy to an individual policy for a period of 180 days.~~

~~2. A member shall have 30 days after the date of termination of group coverage to convert the coverage and pay the initial premium. Any service used within the 30-day conversion period before payment of the initial premium is not covered unless the service was provided or authorized by the member's primary care provider or the HCG Plan.~~

~~3. A member shall pay the initial and subsequent premiums for the converted coverage directly to the HCGA. Conversion coverage is retroactive to the date of termination of group coverage~~.

**R9-27-408. ~~Repealed~~ Contract Compliance Sanction Alternative**

The Director may impose a sanction or penalty upon a HCG plan or employer group that violates any provision of the rules as specified in contract or the GSA.

## ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

**R9-27-502. ~~Reinsurance~~Repealed**

~~**A.** Provision of reinsurance. The HCGA may elect to provide reinsurance through a private reinsurer.~~

~~**B.** Insured entity. For purposes of the HCGA's reinsurance program, the insured entity shall be the HCG Plan with which the HCGA contracts.~~

~~1. The HCGA shall deduct a specified amount per member, per month, from the HCG Plan's monthly premium to cover the cost of the reinsurance contract.~~

~~2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.~~

**R9-27-503. Marketing~~,~~ and ~~Prohibition Against Inducements, Misrepresentation,~~ Discrimination~~, Sanctions~~**

~~**A.** HCGA Plan marketing representatives shall not:~~

~~1. Misrepresent the HCG Plan or the HCG program through false advertising, false statements, or in any other manner in order to induce a member of another contracting entity to enroll in a particular HCG Plan.~~

~~2. Claim, infer, or misrepresent the HCG Plan to be employees of the state or representatives of the HCGA, a county, or an HCG Plan other than the HCG Plan that employs or reimburses them; or~~

~~3. Engage in any marketing or other pre-enrollment practices that discriminate against an applicant or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.~~

~~**B.** HCG Plan to bear responsibility. An HCG Plan shall bear responsibility for any misrepresentation of any marketing representative, subcontractor or agent, program, or process under its employ or direction.~~

HCGA marketing representatives shall not engage in any marketing or other pre-enrollment practices that discriminate against an applicant or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

**R9-27-506. Fraud or Abuse**

Suspected fraud or abuse. All HCG Plans, providers, and ~~nonproviders~~ noncontracting providers shall advise the HCGA immediately in writing of suspected fraud or abuse.

**R9-27-507. Release of Safeguarded Information**

**A.** Information to be safeguarded concerning an applicant or member of ~~a HCG Plan~~ the HCG program includes:

1. Name, address, and social security number;
2. Evaluation of personal information; and
3. Medical data and services including diagnosis and history of disease or disability.

**B.** Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, utilization data, and other information that does not identify an individual applicant or member.

**C.** Safeguarded information concerning a member or applicant shall be disclosed only to:
1. The member or applicant, or, in the case of a minor, the parent, custodial relative, or guardian;
2. Individuals authorized by the member or applicant; and
3. Persons or agencies for official purposes.
4. Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F).

**D.** A member or authorized representative may view the member's medical record after written notification to the provider and at a reasonable time and place.

**E.** Release to individuals authorized by the individual concerned. ~~A~~ The HCGA or a HCG Plan shall release medical records and any other HCG-related confidential information of a member or applicant to individuals authorized by the member or applicant only under the following conditions:
1. Authorization for release of information must be obtained from the member, applicant, or authorized representative. In the case of a minor, the member's or applicant's parent, custodial relative, or guardian shall submit an authorization for release of information.
2. Authorization used for release of information must be, submitted in writing separate from any other document, and must specify the following:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom the release shall be made;
   c. The period of time for which the authorization is valid, if limited; and
   d. The dated signature of the member, applicant, or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial relative, or guardian is required unless the minor is able to understand the consequences of authorizing and not authorizing.
3. If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.

**F.** Release to persons or agencies for official purposes.
1. Safeguarded information, case records, and medical services information may be disclosed without the consent of the member, to agents or employees of a review committee.
2. For purposes of this Section, "review committee" means an organizational structure within the Plan whose primary purpose is to:
   a. Evaluate and improve the quality of health care;
   b. Review and investigate the conduct of licensed health care providers to determine whether disciplinary action should be imposed; and
   c. Encourage proper and efficient utilization of health care services and facilities.
3. Any member, agent, or employee of a review committee, who in good faith and without malice, furnishes records, information, or assistance related to the duties of the review committee; or, who takes an action or makes a decision or recommendation related to the duties or functions of the review committee shall not be subject to liability for civil damages as a consequence of the action. This does not relieve a person of liability that arises from that person's medical treatment of a patient.
4. Information considered by a review committee related to the duties or functions of the committee, including records of their actions and proceedings, are confidential and are not subject to subpoena or order to produce except:
   a. When otherwise subject to discovery as a patient's medical records.
   b. In proceedings before an appropriate state licensing or certifying agency. If the information is transferred to an appropriate state licensing or certifying agency, the information shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions.
5. A member of a review committee or staff engaged in work for the committee or any other person assisting or furnishing information to the review committee shall not be subpoenaed to testify in a judicial or quasi-judicial proceeding if the subpoena is based solely on review committee activities.

**G.** ~~Subcontracting providers shall not be required to obtain written approval from the member before transmitting member medical records to physicians:~~
~~1. Providing services to members under subcontract with the HCG Plan; or~~
~~2. Retained by the subcontractor to provide services that are infrequently used or are of an unusual nature.~~

Subcontractors are not required to obtain written consent from a member before transmitting the eligible person's or member's medical records to a physician who:

1. Provides a service to the eligible person or member under subcontract with the program contractor,
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature, and
3. Provides a service under the contract.

**R9-27-510. Discrimination Prohibition**

**A.** Discrimination. ~~HCG Plans~~ The HCGA or a HCG Plan shall not discriminate against an applicant or a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations promulgated under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered services under contract under A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability includes the following:

1. Denying a member any covered service or availability of a facility for any reason except ~~as defined in a rider~~ provided under R9-27-202 or for a pre-existing condition as described in R9-27-210;
2. Providing a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other HCG members under contract, except when medically indicated;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability of the member to be served.

**B.** Provision of covered services. An HCG Plan shall take affirmative action to ensure that a member is provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except when medically indicated.

## ARTICLE 7. STANDARD FOR PAYMENTS

**R9-27-702. Prohibition Against Charges to Members**

Prohibition against charges to members. An HCG Plan, subcontractor, or noncontracting provider~~, or nonprovider~~ reimbursed by an HCG Plan shall not charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that a member willfully withheld information pertaining to the member's enrollment in an HCG Plan. An HCG Plan shall have the right to recover from a member that portion of payment made by a third party to a member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan.

**R9-27-704. HCG Plan's Liability to Noncontracting ~~and Nonprovider~~ Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members**

**A.** Liability to noncontracting ~~and nonprovider~~ hospitals. An HCG Plan is liable for reimbursement for a member's emergency medical condition:

1. Until the time the member's condition is stabilized and the member is transferable to a subcontractor; or
2. Until the member is discharged post-stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.

**B.** Liability when transfer of member is not possible. Subject to the provisions of subsection (A), if a member cannot be transferred for post-stabilization services to a facility that has a subcontract with the HCG Plan of record, the HCG Plan shall pay the provider for all appropriately documented medically necessary treatment provided the member before the date of discharge or transfer. The reimbursement is the lower of a negotiated discounted rate or prospective tiered-per-diem rate.

**C.** Member refusal of transfer. If a member refuses transfer from a ~~nonprovider or~~ noncontracting hospital to a hospital affiliated with the member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:

1. After consultation with the member's HCG Plan, the member continues to refuse the transfer; and
2. The member is provided and signs a written statement of liability, before the date of discharge or transfer informing the member of the medical impact and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.

**R9-27-705. Copayments**

**A.** Payment of copayment. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.

**B.** Determination of copayment. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:

1. The impact the amount of the copayment will have on the population served, and
2. The copayment amount charged by other group health plans or health insurance carriers for particular services.

**C.** Copayment provisions. The HCGA shall include the copayment provisions in the contract with an HCG Plan and the employer group.

**D.** Schedule of copayments. ~~An HCG Plan~~ HCGA shall provide a schedule of the copayments to members at the time of enrollment.

**R9-27-706. Payments by Employer Groups**

An employer group shall submit the monthly premium payment to the HCGA by the 1st day of the month prior to the month of coverage. The monthly premium payment is delinquent if received or postmarked after the 25th day of the month prior to the month of coverage and subject to R9-27-405 and the GSA.

1. An employer group shall pay the monthly premium to HCGA with sufficient funds in the form of a:
   a. Cashier's check,
   b. Personal check,
   c. Money order,
   d. Automatic debit from a checking or savings account, or
   e. Other means approved by the HCGA.
2. An employer group whose payment is returned for nonsufficient funds shall pay the monthly premium in the form of a:
   a. Cashier's check,
   b. Money order, or
   c. Other means approved by the HCGA.

**R9-27-707. Reinsurance**

**A.** Provision of reinsurance. The HCGA may elect to provide reinsurance through a private reinsurer.

**B.** Insured entity. For purposes of the HCGA's reinsurance program, the insured entity shall be the HCG Plan with which the HCGA contracts.

1. The HCGA shall deduct a specified amount per member, per month, from the employer group's monthly premium to cover the cost of the reinsurance contract.
2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.

## ARTICLE 8. COORDINATION OF BENEFITS

**R9-27-801. Priority of Benefit Payment**

**A.** HCG Plans shall coordinate all third-party benefits. Services provided under the HCG Plan are not intended to duplicate other benefits available to ~~an employee~~ a member.

**B.** Order of payment for members with other insurance. If a member has other coverage, payment for services shall occur in the following order:

1. A policy, plan, or program that has no coordination of benefits provision or nonduplication provision shall make payment first.
2. If a member is covered by another plan or policy that coordinates benefits:
   a. The plan that provides or authorizes the service shall make payment first.
   b. A plan, other than a prepaid plan, that covers a person as an employee shall make payment before a plan that covers the person as a dependent.
3. If coverage is provided to a dependent child and both parents have family coverage:
   a. The plan of the employee whose birthday occurs first in the calendar year shall be primary, and the plan of the employee whose birthday occurs last in the calendar year shall be secondary.
   b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall pay first.
   c. If one of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.
4. If coverage is provided to a dependent child of divorced employees, the order of benefit shall be:
   a. The plan of the employee with custody of the child shall pay first;
   b. The plan of the spouse of the employee with custody of the child shall pay second; and
   c. The plan of the employee not having custody of the child shall pay last.

**C.** Primary payors. An HCG Plan shall not be primary payers for claims involving workers' compensation, automobile insurance, or homeowner's insurance.

**D.** Lien and subrogation rights. An HCG Plan shall ~~not~~ have lien ~~or~~ and subrogation rights ~~beyond~~ as those held by health care services organizations licensed under A.R.S. Title 20, Chapter 4, Article 9.